"STAYING HEALTHY" ASSESSMENT
Children, 0–3 years of age

Patient Stamp

Patient Number _____ Plan Name/Number _____

If patient stamp not used, write in Patient and Plan Name/Number

Child's name (first, last)	Date of birth	Sex	Today's date
		❒ Male ❒ Female	
Your name	Relationship to child ❒ Parent ❒ Guardian ❒ Relative ❒ Friend ❒ Other		

For Clinical Use

Assistance needed:
Reading: ❒ **Yes** ❒ **No**
Interpreter: ❒ **Yes** ❒ **No**

You and your child's health care team can work together towards better health. Please answer these questions as best you can. You may check (✔) "Skip" if you do not know an answer or do not wish to answer. You may talk with your provider about any questions. Your answers will be protected as part of your child's medical record.

Annual Review Date/Initials

					Interventions Code/Date/Initials
	Sample Question and Answer: Does your child go to preschool?	✔ Yes	No	Skip	
	Does Your Home Have:				
1.	A working smoke detector?	Yes	No	Skip	
2.	Water that comes from the faucet hot enough to burn your child?	No	Yes	Skip	
3.	Window guards and stair gates above the first floor?	Yes	No	Skip	
4.	Cleaning supplies, medicines, and matches in a locked cabinet?	Yes	No	Skip	
5.	The phone number for the poison control center posted by your telephone?	Yes	No	Skip	
	Do You:				
6.	Always put your child to sleep on his/her back, if younger than 12 months of age?	Yes	No	Skip	
7.	Ever put your child to sleep with a bottle of juice, milk, or soda?	No	Yes	Skip	
8.	Make sure your child's teeth are brushed every day?	Yes	No	Skip	
9.	Always stay with your child when she/he is in the bathtub?	Yes	No	Skip	
10.	Always put your child in a car seat and seat belt in the back seat of a car?	Yes	No	Skip	
11.	Always walk around your car to check for children before backing out?	Yes	No	Skip	

For Clinical Use

Intervention Codes: **C: Counseling** **EM: Educational Materials** **R: Referral** **F: Follow-up Needed** **SPN: See Progress Notes**

					For Clinical Use **Interventions Code/Date/Initials**
	Does Your Child:				
12.	Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)?	No	Yes	Skip	
13.	Breastfeed?	No	Yes	Skip	
14.	Drink formula, milk, or eat yogurt at least 2 times each day?	Yes	No	Skip	
15.	Eat fruits and vegetables every day?	Yes	No	Skip	
16.	Eat foods that may cause choking such as nuts, popcorn, hotdogs, whole grapes, or hard candy?	No	Yes	Skip	
17.	Spend time at a house or apartment complex with a swimming pool or hot tub?	No	Yes	Skip	
18.	Spend time in a home where a gun is kept?	No	Yes	Skip	
19.	Spend time in a home with anyone who smokes?	No	Yes	Skip	
20.	Often spend time outdoors without sunscreen or other protection such as a hat or shirt?	No	Yes	Skip	
21.	Has your child ever witnessed or been a victim of abuse or violence?	No	Yes	Skip	
22.	**Do you have other questions or concerns about your child's health?** (Please identify) _____ _____ _____ _____	No	Yes	Skip	

For Clinical Use

Intervention Codes: **C: Counseling** **EM: Educational Materials** **R: Referral** **F: Follow-up Needed** **SPN: See Progress Notes**

Privacy Statement

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"STAYING HEALTHY" ASSESSMENT
Children, 4–8 years of age

Patient Stamp

Patient Number _____ Plan Name/Number _____

If patient stamp not used, write in Patient and Plan Name/Number

Child's name (first, last)	Date of birth	Sex	Today's date
		❒ Male ❒ Female	
Your name	Relationship to child		
	❒ Parent ❒ Guardian		
	❒ Relative ❒ Friend ❒ Other		

For Clinical Use

Assistance needed:
Reading: ❒ **Yes** ❒ **No**
Interpreter: ❒ **Yes** ❒ **No**

You and your child's health care team can work together towards better health. Please answer these questions as best you can. You may check (✔) "Skip" if you do not know an answer or do not wish to answer. You may talk with your provider about any questions. Your answers will be protected as part of your child's medical record.

Annual Review Date/Initials

Sample Question and Answer: Does your child play sports?	Yes ✔	No	Skip	**Interventions Code/Date/Initials**
Does Your Home Have:				
1. A working smoke detector?	Yes	No	Skip	
2. Water that comes from the faucet hot enough to burn your child?	No	Yes	Skip	
3. Window guards above the first floor?	Yes	No	Skip	
4. Cleaning supplies, medicines, and matches in a locked cabinet?	Yes	No	Skip	
5. The phone number for the poison control center posted by your telephone?	Yes	No	Skip	
Does Your Child:				
6. Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)?	No	Yes	Skip	
7. See the dentist at least once a year?	Yes	No	Skip	
8. Drink milk or eat yogurt or cheese at least 2 times each day?	Yes	No	Skip	
9. Eat fruits and vegetables every day?	Yes	No	Skip	
10. Eat only a limited amount of fried or fast foods?	Yes	No	Skip	

For Clinical Use

Intervention Codes: **C: Counseling** **EM: Educational Materials** **R: Referral** **F: Follow-up Needed** **SPN: See Progress Notes**

					For Clinical Use Interventions Code/Date/Initials
	Does Your Child:				
11.	Play actively 5 days a week?	Yes	No	Skip	
12.	Need to lose or gain weight?	No	Yes	Skip	
13.	Ever play in the street or unsupervised in the front yard?	No	Yes	Skip	
14.	Always use a booster seat and seat belt when riding in a car?	Yes	No	Skip	
15.	Always wear a helmet when riding a bike or skateboard?	Yes	No	Skip	
16.	Spend time at a house or apartment complex with a swimming pool or hot tub?	No	Yes	Skip	
17.	Spend time in a home where a gun is kept?	No	Yes	Skip	
18.	Spend time in a home with anyone who smokes?	No	Yes	Skip	
19.	Often spend time outdoors without sunscreen or other protection such as a hat or shirt?	No	Yes	Skip	
	Has Your Child:				
20.	Ever witnessed or been a victim of abuse or violence?	No	Yes	Skip	
21.	Had any problems at home or school?	No	Yes	Skip	
22.	**Do you have other questions or concerns about your child's health?** (Please identify) _____ _____ _____ _____	No	Yes	Skip	

For Clinical Use

Intervention Codes: **C: Counseling** **EM: Educational Materials** **R: Referral** **F: Follow-up Needed** **SPN: See Progress Notes**

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"STAYING HEALTHY" ASSESSMENT
Pre-adolescents, 9–11 years of age

Patient Stamp

Patient Number _____ Plan Name/Number _____

If patient stamp not used, write in Patient and Plan Name/Number

Child's name (first, last)	Date of birth	Sex	Today's date
		❒ Male ❒ Female	
Your name	Relationship to child ❒ Parent ❒ Guardian ❒ Relative ❒ Friend ❒ Other		

For Clinical Use

Assistance needed:
Reading: ❒ **Yes** ❒ **No**
Interpreter: ❒ **Yes** ❒ **No**

You and your child's health care team can work together towards better health. Please answer these questions as best you can. You may check (✔) "Skip" if you do not know an answer or do not wish to answer. You may talk with your provider about any questions. Your answers will be protected as part of your child's medical record.

Annual Review Date/Initials

Sample Question and Answer: Does your child go to school?	✔ Yes	No	Skip

Interventions Code/Date/Initials

Does Your Child:

1.	Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)?	No	Yes	Skip
2.	See the dentist at least once a year?	Yes	No	Skip
3.	Drink milk or eat yogurt or cheese at least 3 times each day?	Yes	No	Skip
4.	Eat fruits and vegetables every day?	Yes	No	Skip
5.	Eat only a limited amount of fried or fast foods?	Yes	No	Skip
6.	Play actively 5 days a week?	Yes	No	Skip
7.	Need to lose or gain weight?	No	Yes	Skip
8.	Often feel sad or depressed?	No	Yes	Skip
9.	Always wear a helmet when riding a bike or skateboard?	Yes	No	Skip
10.	Always wear a seatbelt when riding in a car?	Yes	No	Skip
11.	Spend time in a home where a gun is kept?	No	Yes	Skip

For Clinical Use

Intervention Codes: **C: Counseling** **EM: Educational Materials** **R: Referral** **F: Follow-up Needed** **SPN: See Progress Notes**

					For Clinical Use **Interventions Code/Date/Initials**
	Does Your Child:				
12.	Spend time with any friends who carry a gun, knife, club, or other weapon?	No	Yes	Skip	
13.	Spend time in a home with anyone who smokes?	No	Yes	Skip	
14.	Often spend time outdoors without sunscreen or other protection such as a hat or shirt?	No	Yes	Skip	
	Has Your Child:				
15.	Ever smoked cigarettes or chewed tobacco?	No	Yes	Skip	
16.	Ever had alcohol such as beer, wine, wine coolers, or liquor?	No	Yes	Skip	
17.	Ever smoked marijuana, sniffed glue, or used street drugs?	No	Yes	Skip	
18.	Had friends or family members who had a problem with drugs or alcohol?	No	Yes	Skip	
19.	Started dating or "going with" boyfriends/girlfriends?	No	Yes	Skip	
20.	Become sexually active?	No	Yes	Skip	
21.	Ever been molested or sexually abused?	No	Yes	Skip	
22.	Ever witnessed or been a victim of physical abuse or violence?	No	Yes	Skip	
23.	Had problems at home or school?	No	Yes	Skip	
24.	**Do you have other questions or concerns about your child's health?** (Please identify) _____ _____ _____ _____	No	Yes	Skip	

For Clinical Use

Intervention Codes: **C: Counseling** **EM: Educational Materials** **R: Referral** **F: Follow-up Needed** **SPN: See Progress Notes**

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"STAYING HEALTHY" ASSESSMENT
Adolescents, 12–17 years of age

Patient Stamp

Patient Number _____ Plan Name/Number _____

If patient stamp not used, write in Patient and Plan Name/Number

Patient's name (first, last)	Date of birth	Sex	Today's date
		❒ Male ❒ Female	
Name of person completing form (if other than patient)	Relationship		
	❒ Parent ❒ Relative	❒ Guardian ❒ Friend	❒ Other

For Clinical Use

Assistance needed:
Reading: ❒ **Yes** ❒ **No**
Interpreter: ❒ **Yes** ❒ **No**

You and your health care team can work together towards better health. Please answer these questions as best you can. You may check (✔) "Skip" if you do not know an answer or do not wish to answer. You may talk with your provider about any questions. Your answers will be protected as part of your medical record.

Annual Review Date/Initials

	Sample Question and Answer: Do you play sports?	✔ Yes	No	Skip	**Interventions Code/Date/Initials**
	Do you:				
1.	Live at home?	Yes	No	Skip	
2.	Go to school?	Yes	No	Skip	
3.	Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)?	No	Yes	Skip	
4.	See the dentist at least once a year?	Yes	No	Skip	
5.	Drink milk or eat yogurt or cheese at least 3 times each day?	Yes	No	Skip	
6.	Eat fruits and vegetables every day?	Yes	No	Skip	
7.	Try to limit the amount of fried or fast foods that you eat?	Yes	No	Skip	
8.	Exercise or play an active sport 5 days a week?	Yes	No	Skip	
9.	Think you need to lose or gain weight?	No	Yes	Skip	
10.	Often feel sad, down, or hopeless?	No	Yes	Skip	
11.	Always wear a seat belt when riding in a car?	Yes	No	Skip	
12.	Always wear a helmet when riding a bike or skateboard?	Yes	No	Skip	
13.	Spend time in a home where a gun is kept?	No	Yes	Skip	
14.	Spend time in a home with anyone who smokes?	No	Yes	Skip	
15.	Often spend time outdoors without sunscreen or other protection such as a hat or shirt?	No	Yes	Skip	

For Clinical Use

Intervention Codes: **C: Counseling** **EM: Educational Materials** **R: Referral** **F: Follow-up Needed** **SPN: See Progress Notes**

Your answers to questions about sex and family planning cannot be shared with anyone, including your parents, without your special written permission.					*For Clinical Use* **Interventions Code/Date/Initials**
	Do you ever:				
16.	Smoke cigarettes or cigars or chew tobacco?	No	Yes	Skip	
17.	Drink alcohol such as beer, wine, wine coolers, or liquor?	No	Yes	Skip	
18.	Drive a car after drinking or ride in a car driven by someone who has been drinking?	No	Yes	Skip	
19.	Use drugs such as marijuana, cocaine, crack, crank, or ecstasy?	No	Yes	Skip	
20.	**Have you ever had sex?** *If "yes," continue to next question. If "no," go to question 26.*	No	Yes	Skip	
21.	Do you think you or your partner could be pregnant?	No	Yes	Skip	
22.	Have you had sex without using birth control in the last year?	No	Yes	Skip	
23.	Do you think you or your partner could have a sexually transmitted disease?	No	Yes	Skip	
24.	Have you or your partner(s) had sex with any other people in the past year?	No	Yes	Skip	
25.	Did you or your partner use a condom the last time you had sex?	Yes	No	Skip	
	Have you:				
26.	Ever been forced or pressured to have sex?	No	Yes	Skip	
27.	Ever been hit, slapped, kicked, or physically hurt by someone?	No	Yes	Skip	
28.	Ever carried a gun, knife, club, or other weapon?	No	Yes	Skip	
29.	**Do you have other questions or concerns about your health?** (Please identify) _____ _____ _____ _____	No	Yes	Skip	

For Clinical Use

Intervention Codes: **C: Counseling** **EM: Educational Materials** **R: Referral** **F: Follow-up Needed** **SPN: See Progress Notes**

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"STAYING HEALTHY" ASSESSMENT
Adults, 18 years of age and older

Patient Stamp

Patient Number _____ Plan Name/Number _____

If patient stamp not used, write in Patient and Plan Name/Number

Patient's name (first, last)	Date of birth	Sex ❒ Male ❒ Female	Today's date	***For Clinical Use*** **Assistance needed:** **Reading:** ❒ Yes ❒ No **Interpreter:** ❒ Yes ❒ No

You and your health care team can work together towards better health. Please answer these questions as best you can. You may check (✔) "Skip" if you do not know an answer or do not wish to answer. You may talk with your provider about any questions. Your answers will be protected as part of your medical record.

Sample Question and Answer: Do you play sports?	Yes ✔	No	Skip	**Interventions Code/Date/Initials**
Do You:				
1. Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)?	No	Yes	Skip	
2. See the dentist at least once a year?	Yes	No	Skip	
3. Drink milk or eat yogurt or cheese at least 3 times each day?	Yes	No	Skip	
4. Eat fruits and vegetables every day?	Yes	No	Skip	
5. Try to limit the amount of fried or fast foods that you eat?	Yes	No	Skip	
6. Exercise or do moderate physical activity such as walking or gardening 5 days a week?	Yes	No	Skip	
7. Think you need to lose or gain weight?	No	Yes	Skip	
8. Often feel sad, down, or hopeless?	No	Yes	Skip	
9. Have friends or family members that smoke in your home?	No	Yes	Skip	
10. Often spend time outdoors without sunscreen or other protection such as a hat or shirt?	No	Yes	Skip	

Annual Review Date/Initials

For Clinical Use

Intervention Codes: **C: Counseling** **EM: Educational Materials** **R: Referral** **F: Follow-up Needed** **SPN: See Progress Notes**

Your answers to questions about alcohol and drug use cannot be released to others without your special written permission.

					For Clinical Use **Interventions Code/Date/Initials**
	Do You:				
11.	Smoke cigarettes or cigars or use any other kinds of tobacco?	No	Yes	Skip	
12.	Use any drugs or medicines to go to sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
13.	Often have more than 2 drinks containing alcohol in one day?	No	Yes	Skip	
14.	Think you or your partner could be pregnant?	No	Yes	Skip	
15.	Think you or your partner could have a sexually transmitted disease?	No	Yes	Skip	
	Have You:				
16.	Or your partner(s) had sex without using birth control in the last year?	No	Yes	Skip	
17.	Or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
18.	Or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
19.	Ever been forced or pressured to have sex?	No	Yes	Skip	
20.	Ever been hit, slapped, kicked, or physically hurt by someone?	No	Yes	Skip	
21.	**Do you have other questions or concerns about your health?** (Please identify) _____ _____ _____ _____	No	Yes	Skip	

For Clinical Use

Intervention Codes: **C: Counseling** **EM: Educational Materials** **R: Referral** **F: Follow-up Needed** **SPN: See Progress Notes**

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